HEALTH SERVICES UTILIZATION

Availability of and access to quality health services directly affect the health and well-being of women. For women with poor health status, disabilities, poverty, lack of insurance, and limited access to a range of health services, preventive treatment, and rehabilitation can be critical in preventing disease and improving women's quality of life.

The following section presents data on women's health services utilization, including indicators on insurance, usual source of care, medication use, and use of preventive, dental, hospital, and mental health services.

USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency room, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2003, the percentage of women reporting a usual source of care rose with age, from a low of 81.8 percent among women 18 to 24 years of age, to a high of 97.3 percent among those aged 65 years and older.

Usual sources of care varied among racial and ethnic groups. Hispanic women were the most likely to report no usual source of care (19.8 percent). Non-Hispanic White women were the most likely to report an office setting as a usual source of care (90.7 percent), while non-Hispanic Black women were the most likely to use a hospital outpatient clinic or an emergency room as a usual source of care (3.2 and 1.6 percent, respectively).

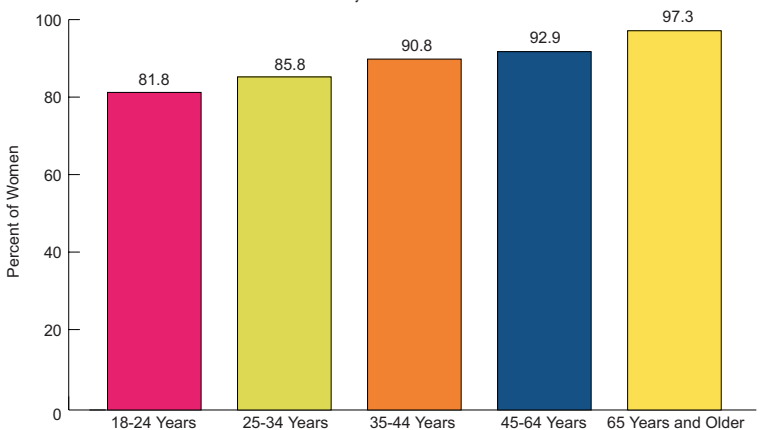
1 *Ettner SL. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference? Medical Care 1999;37(6):647-55.*

2 *Sox CM, Swartz K, Burstin HR, Brennan TA. Insurance or a regular physician: which is the most powerful predictor of health care? American Journal of Public Health 1998;88(3):364-70.*

3 *Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. American Journal of Public Health 1996;86(12):1742-7.*

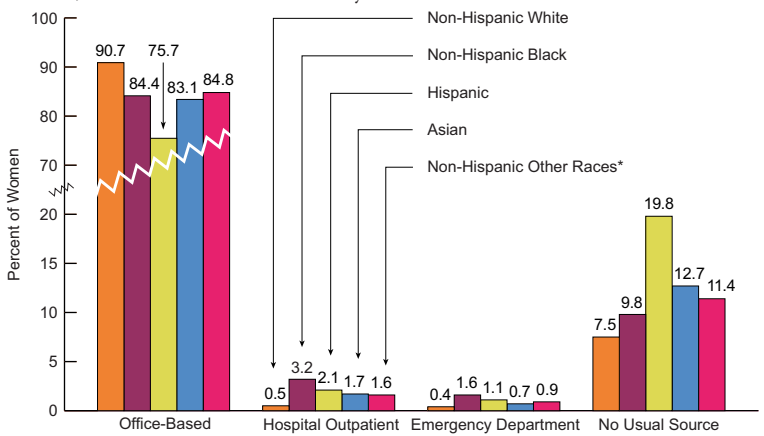
Women Aged 18 and Older with a Usual Source of Care, by Age, 2003

Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Usual Source of Care for Women Aged 18 and Older, by Race/Ethnicity, 2003

Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Includes Native American/Alaska Native and persons of more than one race.

HEALTH INSURANCE

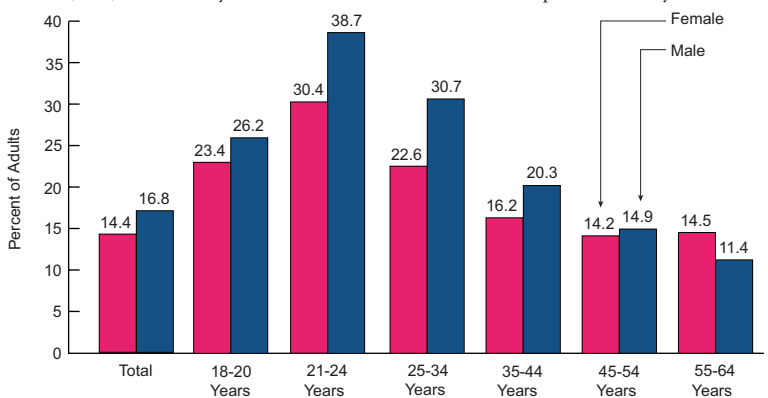
People who are uninsured are less likely than those with insurance to seek preventive care, which can result in poor health outcomes and higher health care costs. In 2003, 45 million people in the U.S., representing 15.6 percent of the population, were uninsured all year. The percentage of people who are uninsured varies considerably across a number of categories, including sex, age, race/ethnicity, income, and education. The percentage of females without insurance (14.4 percent) is slightly lower than the percentage of males (16.8 percent). However, non-White women are more likely than White women to lack coverage: 10.4 percent of non-Hispanic White females (of all ages) were uninsured, compared to 17.8 percent of Black females, 18.5 percent of Asian females, and 29.6 percent of Hispanic females.

The percentage of people without health insurance also varies greatly by age. Young adults of both sexes are the most likely to be uninsured: 34.5 percent of 21 to 24 year-olds lack health insurance, as do 26.6 percent of 25 to 34 year-olds. In contrast, because of the Medicare program, fewer than 1 percent of women aged 65 years and older are uninsured.

Rates of uninsurance decrease steadily as household income increases, ranging from a high of 24.2 percent for those with incomes below $25,000 to a low of 8.2 percent for those with incomes of $75,000 or more.

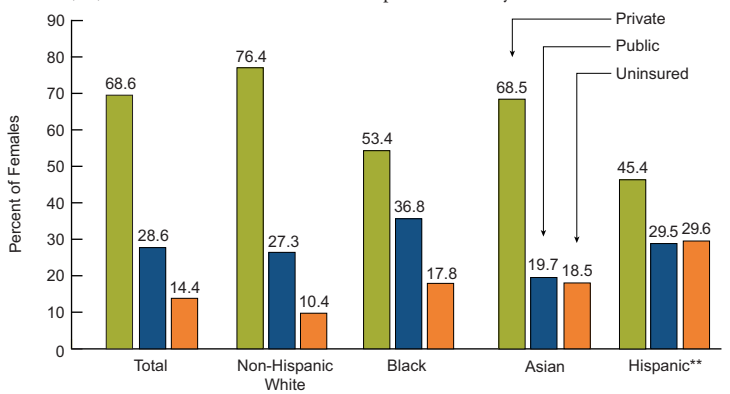
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2003

Source (III.1): EBRI Analysis of U.S. Census Bureau, Current Population Survey



Health Insurance Coverage* of Females, by Type of Coverage and Race/Ethnicity, 2003

Source (I.9): U.S. Census Bureau, Current Population Survey



*Individuals may receive coverage from more than one source.
** May be of any race.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services.

Indicators used to monitor women's health care in managed care plans include the timeliness of prenatal care, receipt of postpartum checkups after delivery, screening for chlamydia, screening for cervical cancer, and receipt of mammograms. The accessibility of most of these services is increasing in commercial, Medicare, Medicaid managed care plans.

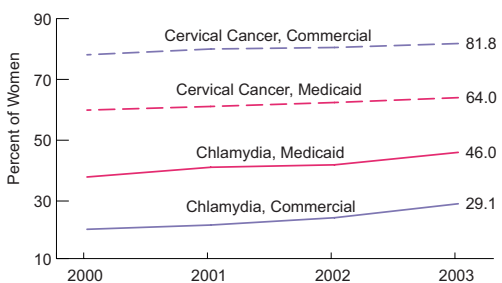
Perinatal services—prenatal care and postpartum checkups—appear to be more accessible in commercial (private) plans than in public-sector plans financed by Medicaid. The same is true of cervical cancer screening, which is received at least once every 3 years by nearly 82 percent of commercially-insured women and 64 percent of women covered by Medicaid.

In 2003, the rate of breast cancer screening (mammograms) for women aged 52-69 was approximately equal for women in private plans and those covered through Medicare. However, Medicaid-enrolled women in this age group are considerably less likely to receive a mammogram at least once every 2 years.

Chlamydia screening is the one screening service that is more common among Medicaid-enrolled women than those with private coverage: 46 percent of Medicaid-enrolled women aged 21-25 had a chlamydia screen in the previous year, compared to 29 percent of commercially-insured women.

HEDIS®* Rates of Cervical Cancer** and Chlamydia*** Screening, by Payer, 2000-2003

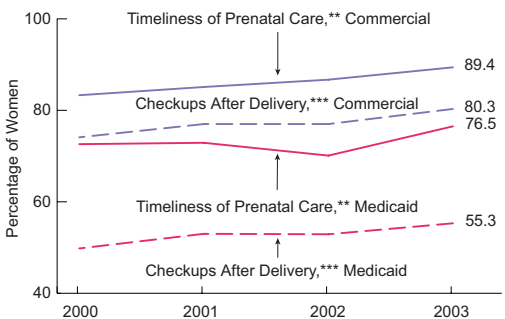
Source (II.13): National Committee for Quality Assurance



*HEDIS® (Health Plan Employer Data and Information Set) is a registered trademark of NCQA.
**The percentage of women aged 21-64 who had at least one Pap test in the past three years.
***The percentage of sexually active plan members aged 21-25 who had at least one test for chlamydia in the past year.

HEDIS®* Measures of Perinatal Care, by Payer, 2000-2003

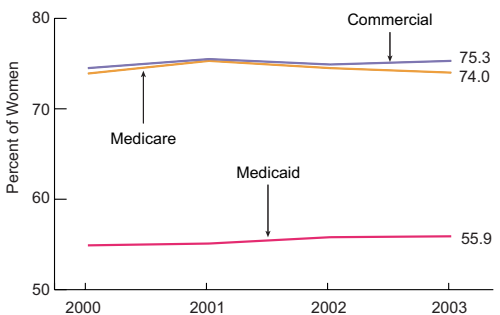
Source (II.13): National Committee for Quality Assurance



**The percentage of women beginning their prenatal care in first trimester or within 43 days of enrollment if pregnant at enrollment.
***The percentage of women who had a visit to their health care provider between 21 and 56 days after delivery.

HEDIS®* Rates of Mammograms,** by Payer, 2000-2003

Source (II.13): National Committee for Quality Assurance



**The percentage of women aged 52-69 years who had at least one mammogram in the past two years.

MEDICARE AND MEDICAID

Medicare is the Nation's health insurance program for people aged 65 and older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The Medicare program has two components: Part A, which covers hospital, skilled nursing, home health, and hospice care, and Part B, which covers physician services, outpatient hospital services, and durable medical equipment. Among the preventive services covered by Medicare are an annual mammogram, Pap smear, bone density scan, and influenza vaccination.

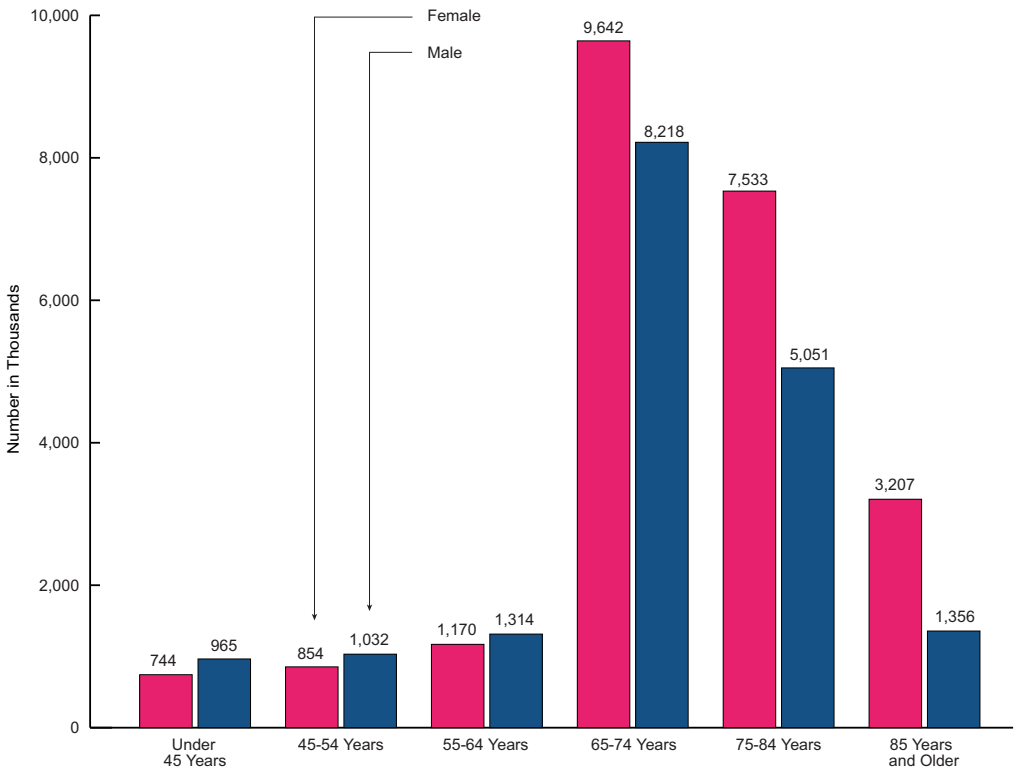
In 2003, Medicare had over 41 million enrollees, of whom 56 percent were female. The large majority of all Medicare enrollees were aged 65 or older, with the elderly representing 88 percent of female enrollees and 82 percent of males.

Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income individuals and people with disabilities. In 2002, Medicaid covered 51.5 million individuals, including children; the aged, blind, and disabled; and people who are eligible for cash assistance programs. Sixty percent of Medicaid enrollees were female. Of all Medicaid enrollees, 54 percent were under age 21, 35 percent were between the ages of 21 and 64, and 11 percent were aged 65 and older.[1]

1 *Center for Medicare and Medicaid Services, Medicaid Statistical Information System.*

Medicare Enrollees (All Ages), by Age and Sex, 2003

Source (III.2): Center for Medicare and Medicaid Services



PREVENTIVE CARE

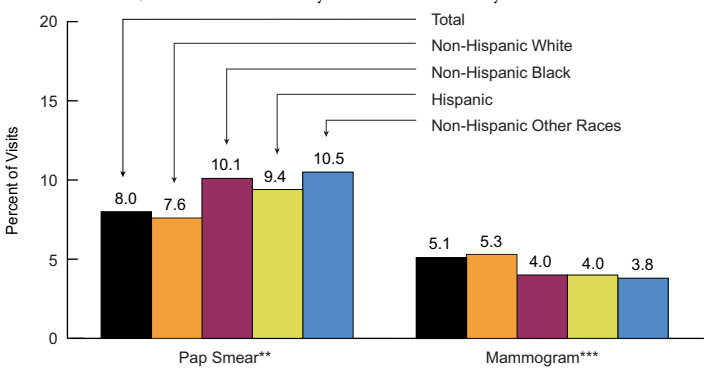
Counseling, education, and screening can promote healthy behaviors that prevent or minimize the occurrence of many serious health conditions. In 2002, females of all ages made almost 530 million physician office visits, compared to only 361 million visits made by males. Of visits made by females, 18.3 percent were for preventive care, including prenatal care, screenings, and insurance examinations. Women aged 25 to 44 years made the most preventive visits (23.5 percent), followed by those under 15 years of age (14.6 percent).

Mammograms and Pap smears are two preventive services that are especially important to women's health. The U.S. Preventive Services Task Force recommends that Pap smears to screen for cervical cancer begin within three years from the initiation of sexual activity, or at age 21, whichever comes first. The Task Force recommends mammography every one to two years for women aged 40 and older. In 2002, 8.0 percent of all office visits made by women 18 and older included a Pap smear, and 5.1 percent of all office visits made by women 40 and older included a mammogram.

Counseling and education are sometimes offered during physician visits. In 2002, counseling or education related to nutrition was offered during 15.0 percent of visits made by females. Other types of counseling or education that were offered include exercise (10.5 percent of visits), mental health (4.9 percent), and weight reduction (3.9 percent).

Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits, by Race/Ethnicity,* 2002

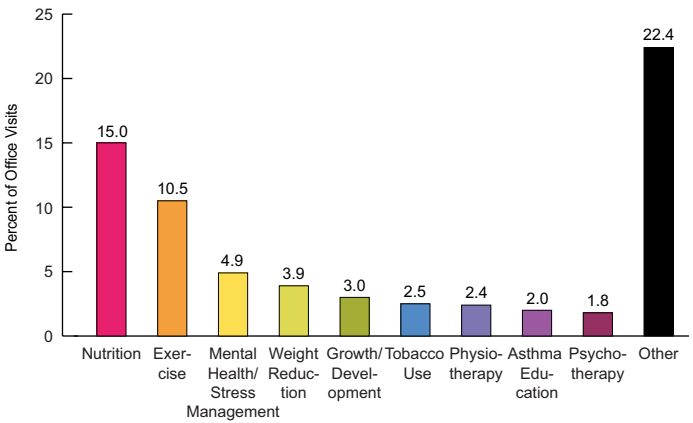
Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Rates are not age-adjusted.
**Among women aged 18 and older.
***Among women aged 40 and older.

Counseling/Education Provided to Females (All Ages) During Office Visits, 2002

Source (III.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



HIV TESTING

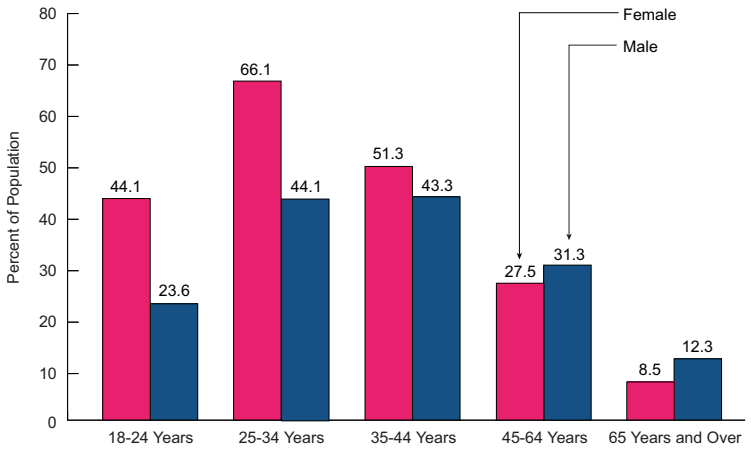
Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek appropriate care. HIV testing requires only a simple blood or saliva test, and it is often offered through confidential and/or anonymous sources.

As of 2003, almost 36 percent of U.S. adults had ever been tested for HIV. Of all adults, women between the ages of 25 and 34 were most likely to report ever being tested. Among the younger population, women were more likely to have been tested than men; however, among the older population the opposite was true. Older men were more likely to have been tested than their female counterparts.

In 2003, there were racial and ethnic differences in testing rates among women. Non-Hispanic Black women had the highest rate of HIV testing (54.4 percent), followed by Hispanic women (46.7 percent); Asian women and non-Hispanic White women had the lowest rates of testing (34.0 and 33.9 percent, respectively).

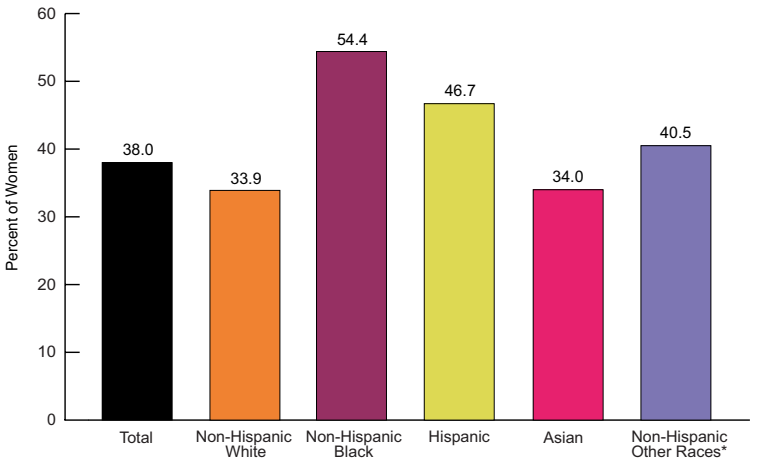
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2003

Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2003

Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Includes American Indian/Alaska Native and those of more than one race.

MEDICATION USE

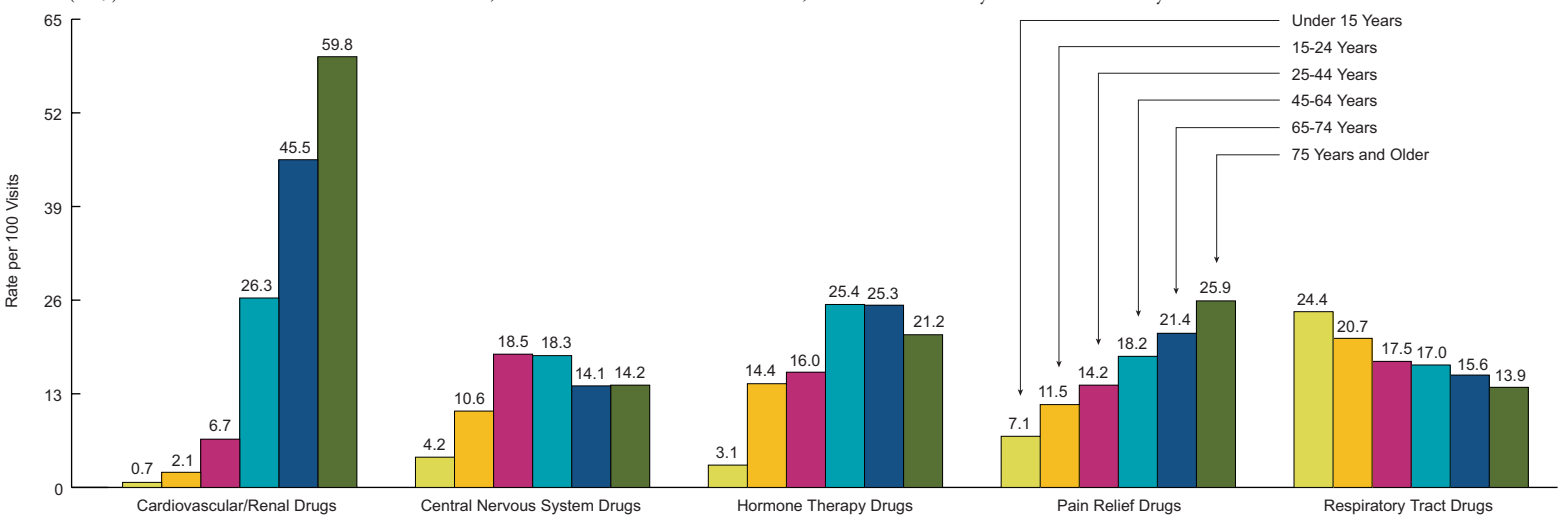
In 2002, medication was prescribed or provided at 577.1 million physician office visits, which represents 1.3 billion prescriptions. The percent of visits at which one or more drugs was prescribed or provided was slightly higher for females than males (65.5 compared to 63.9 percent). The overall drug mention rate was similar between 2001 and 2002; however, the rate at obstetrics/gynecology visits increased 48 percent, due in part to an increase in the discussion of contraceptives and vitamins.[1]

The use of medications among females varies by age and drug type. In 2002, the use of cardiovascular/renal and pain relief drugs among women increased with age, while respiratory tract drug use decreased with age. Discussions about central nervous system drugs, including antidepressives, during physician visits were most common among women in the middle age groups, with the highest rate occurring among women aged 25-44 (18.5 percent of office visits). The most commonly mentioned drug types were cardiovascular/renal drugs among women 75 and older (59.8 percent of visits). The lowest rate was for cardiovascular/renal drugs among females under the age of 15 (0.7 percent of visits). Among females under age 15, respiratory tract drugs were most likely to be discussed (24.4 percent of visits).

1 *Woodwell DA, Cherry DK. National Ambulatory Medical Care Survey: 2002 summary. Advance Data from Vital and Health Statistics, No. 346, August 2004.*

Medication Use Reported for Females During Physician Office Visits, by Age, 2002

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



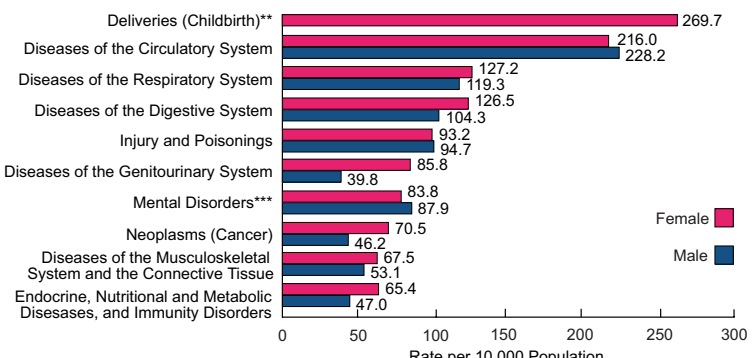
HOSPITALIZATIONS

Females represented 60.3 percent of the nearly 34 million short-stay hospital discharges in 2002. Among all hospital discharges among females, women aged 15-44 years accounted for 38.5 percent, due in part to hospitalizations for childbirth, while women 65 years and older accounted for another 36.4 percent. Nearly one-fifth of discharges for all females were for childbirth, and one-quarter of all procedures performed on females were obstetrical in nature. Other common diagnoses were diseases of the circulatory system (16 percent of female discharges), diseases of the respiratory system, and diseases of the digestive system (9 percent each).

Overall, females had a higher hospital discharge rate than males (1,388 compared to 952.3 per 10,000 population). Differences existed between the discharge rate of males and females for every category of primary diagnosis and for every type of procedure performed. Several of the diagnoses for which women had a higher discharge rate than men included diseases of the digestive system (126.5 compared to 104.3 per 10,000 population), genitourinary system diseases, such as kidney diseases (85.8 compared to 39.8 per 10,000), and neoplasms (70.5 compared to 46.2 per 10,000). Most commonly, women were discharged for obstetrical procedures (453.6 per 10,000). The discharge rate of females was higher for almost all of the most common procedures, including operations on the digestive system, operations on the musculoskeletal system, and operations on the integumentary system, such as treatments for wounds or burns.

Discharges from Non-Federal, Short Stay Hospitals, by Sex and Primary Diagnosis (All Ages),* 2002

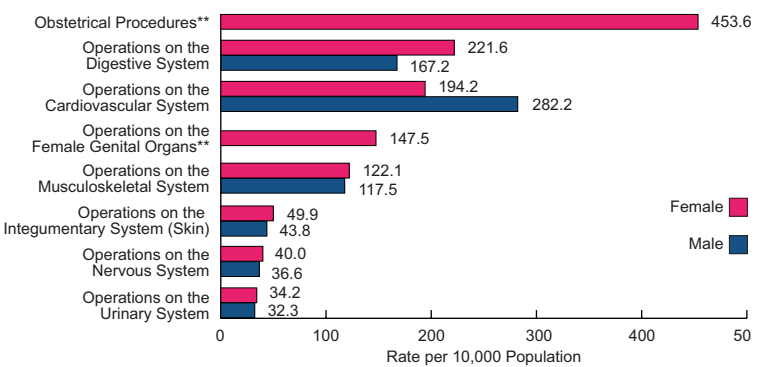
Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants
**Not applicable to males.
***Includes alcohol and drug dependence syndrome

Discharges from Non-Federal, Short Stay Hospitals, by Sex and Procedure Category (All Ages),* 2002

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



ORGAN TRANSPLANTATION

During 2003, there were 25,462 organ transplants in the United States. Since 1988, the number of organ transplants has increased each year. The gender distribution among organ donors was fairly even in 2003 (6,644 females and 6,634 males donated organs.) In 2003, women were more likely than men to donate organs while alive (58.4 percent of living donors were women).

Waiting lists for organs continue to increase because the need for donated organs greatly outweighs the availability. As of February 11, 2005, there were 87,178 people certified for a transplant and waiting for organs. Females made up 37.9 percent of those receiving transplants in 2003 and 42.2 percent of those on the waiting list. Racial and ethnic minorities are disproportionately represented among women waiting for an organ. Among women on the waiting list, 28.5 percent were Blacks and 15.3 percent were Hispanics. The kidney was the organ in highest demand, with a total of 60,859 individuals awaiting a kidney, 42 percent of whom were female.

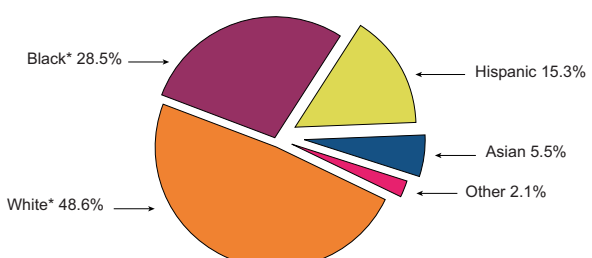
Although there has been an increase in organ donations each year since 1988, obtaining consent for organ donation has been challenging. Consent primarily must be obtained from the donor family or a legal surrogate. Some of the reasons consent rates vary include religious perceptions, poor communication between grieving families and health care providers, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased. Race and ethnicity also appear to be a strong predictor of willingness to consent to donation.[1]

The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are administered by HRSA's Healthcare Systems Bureau (HSB). Other programs administered by HSB include the National Marrow Donor Program, the National Cord Blood Stem Cell Bank, the National Vaccine Injury Compensation Program, and the Smallpox Emergency Personnel Protection Act Program.

1 2003 OPTN/SRTR Annual Report: Transplant Data 1992-2002. HHS/HRSA/SPB/DOT; UNOS; URREA.

Distribution of Females on Organ Waiting List, by Race/Ethnicity on February 11, 2005

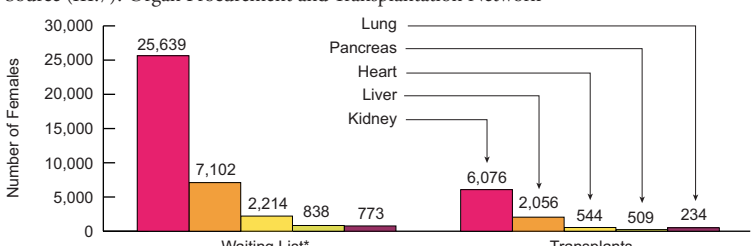
Source: (III.7) Organ Procurement and Transplantation Network



** Includes Hispanic*

Female Transplant Recipients, 2003, and Females on Transplant Waiting Lists, 2005, by Organ

Source (III.7): Organ Procurement and Transplantation Network



**On February 11, 2005*

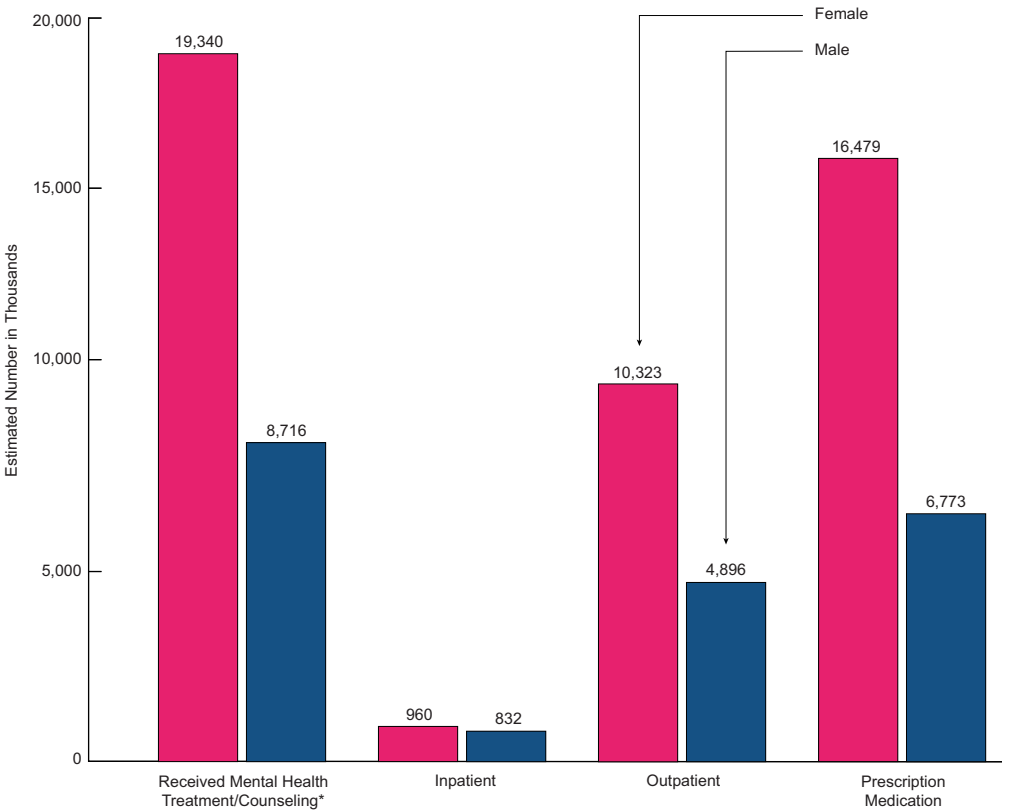
MENTAL HEALTH CARE UTILIZATION

In 2003, an estimated 27.3 million U.S. adults reported receiving mental health treatment in the past year. Women represented more than two-thirds of users of mental health services. The most common type of treatment obtained by adults was prescription medication, followed by outpatient treatment. Nearly 16.5 million women and 6.8 million men used prescription medication for treatment of a mental or emotional condition.

Mental health services are needed, but not received, by millions of adults in this country. Those with serious mental illness are in particular need of services. In 2003, of the 12.7 million women aged 18 or older who reported having a serious mental illness in the past year, nearly one-half (6.1 million women) did not report receiving any type of mental health treatment or counseling. When asked to define their own perceived unmet need, 30.1 percent of adults with serious mental illness reported an unmet need for treatment or counseling for problems with emotions, nerves or mental health. Cost was the reason most often cited for not receiving needed mental health treatment.

Adults Aged 18 and Older Receiving Mental Health Treatment,* by Sex and Treatment/Counseling Type, 2003

Source (II.4): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excluding treatment for alcohol or drug use.

HEALTH CARE EXPENDITURES

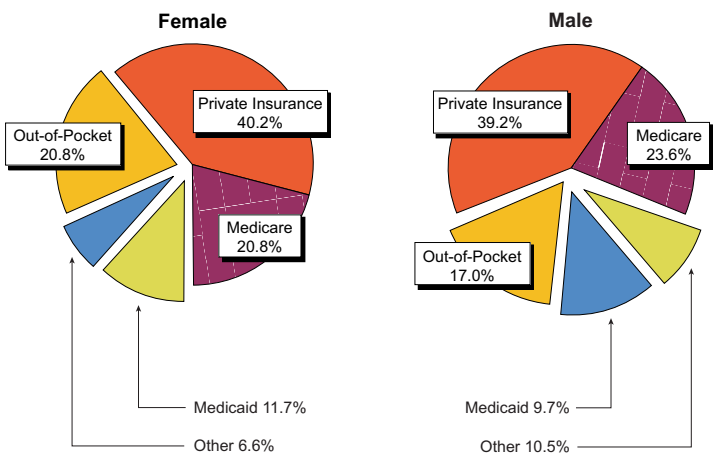
In 2002, the majority of both women's and men's health care expenses were covered by public or private health insurance. For women, approximately one-third of expenses were covered by either Medicare or Medicaid, while just over 40 percent were covered by private insurance. Although the percentage of expenditures paid through private insurance was approximately equal for women and men, women's health care costs were more likely than men's to be paid by Medicaid or out of pocket.

Ninety percent of females had at least one health care expenditure in 2002, compared to 80 percent of males. Among those who had at least one health care expense in 2002, the average per-person expenditure was higher for females ($3,461) than for males ($3,116). However, men's expenditures exceeded women's for hospital inpatient services ($14,221 compared to $10,371), home health services, and hospital outpatient services, while women's expenditures exceeded men's in the categories of office-based medical services and prescription drugs.

While the gender gap in health care expenditures has narrowed somewhat since 1998, overall per-capita health care expenditures have increased substantially among both men and women. Men's expenses have increased 46 percent over this period while women's have gone up 28 percent.

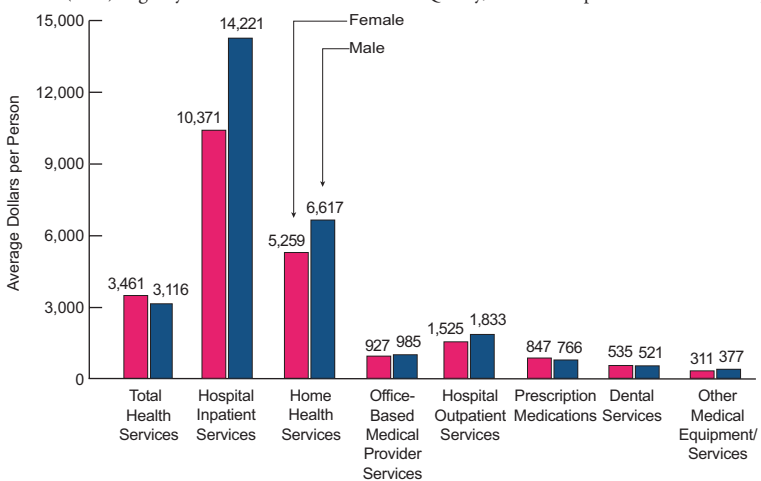
Health Care Expenses, by Source of Payment and Sex (All Ages), 2002

Source (III.8): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 2002

Source (III.8): Agency for Healthcare Research and Quality, Medical Expenditure Panel Surve



HRSA PROGRAMS

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services supports a wide range of programs that increase and promote access to health care for vulnerable groups. HRSA's five Bureaus—the Maternal and Child Health Bureau, Bureau of Health Professions, HIV/AIDS Bureau, Bureau of Primary Health Care, and Healthcare Systems Bureau—as well as the Office of Rural Health Policy, all support programs that address the specific needs of women. Highlighted below are some core programs representing a few ways that HRSA serves women across the lifespan.

The Nation's network of **Federally Qualified Health Centers (FQHCs)** provide low-cost primary health care services to women, men, and children who are uninsured or underinsured, or who lack access to private-sector providers. Of the 12.4 million people served by FQHCs in 2003, 7.3 million, or 59 percent, were female.

All **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act** programs serve women. In 2003, 352,334 (31.4 percent) of the 1,121,032 clients served by CARE Act providers were females. This includes both HIV-infected and -affected clients. The CARE Act's Title IV is the cornerstone of the Act's response to HIV/AIDS among underserved women, infants, children and youth. Comprehensive care for pregnant women has been shown to be equally critical in reducing perinatal transmission rates, which at some Title IV sites is zero percent.

AIDS Drug Assistance Programs funded under Title II of the CARE Act, provide HIV-related prescription drugs to people with HIV/AIDS who have limited or no prescription drug coverage. The programs serve approximately 136,000 clients each year. In June 2003, the programs served a total of 85,825 clients, 21 percent of whom were women.[1]

The **Bureau of Health Professions'** Division of Health Careers Diversity and Development is committed to developing culturally competent health professionals by ensuring grantees have implemented policies, practices, and initiatives which demonstrate their commitment to diverse populations in need. The Division of Medicine and Dentistry supports cultural competency training through grants and contracts, such as Cultural Competency in Medical Education: A Guidebook for Schools, developed under a contract with the American Medical Student Association Foundation.

The mission of the **Maternal and Child Health Block Grant Program** is to assure the health of all mothers and children, including children with special health care needs. All programs work to reduce infant mortality and incidence of handicapping conditions among children; increase the number of appropriately immunized children; increase the number of children in low-income households who receive assessments and follow-up services; and provide and ensure access to comprehensive perinatal care for women. The development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children with special health care needs is also part of the Block Grant Program.

1 *Davis MD, Aldridge C, Penner M, Kates J, Chou L, Kubert D. National ADAP Monitoring Project Annual Report, May 2004.*

Percent of Infants Born to Women Receiving Prenatal Care Beginning in the First Trimester, by States, 2003

Source: (III.3) Health Resources and Services Administration, Maternal and Child Health Bureau, Title V Information System